DISABLED RESIDENT LIFETIME LICENSES
PHYSICIANS' AFFIDAVITS
NOTE: THIS FORM MUST BE COMPLETED BY TWO PHYSICIANS

1) AFFIDAVIT WITHOUT PHYSICAL EXAM
Physician's Certification (To be completed by physician)

Physician's Name _____
(**Please Print**)
Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____-_____
Briefly describe applicant's disability(s): (Use additional sheets if necessary)

Physician's Statement: It is my professional opinion that _____
Name of Applicant
is permanently and totally disabled and is unable to engage in any substantial gainful activity by reason of a physical or mental impairment or deformity which I have determined and expect to last for the duration of his or her life. By signing this statement I certify that the information provided in the Physician's Statement is true and correct and that I am currently a licensed physician in _____(State).

_____ _____
Physician's Signature **Date**

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2) AFFITDAVIT WITH PHYSICAL EXAM
Physician's Certification (To be completed by physician)

Physician's Name _____
(**Please Print**)
Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____-_____
Briefly describe applicant's disability(s): (Use additional sheets if necessary)

Physician's Statement: It is my professional opinion that _____
Name of Applicant
is permanently and totally disabled and is unable to engage in any substantial gainful activity by reason of a physical or mental impairment or deformity which I have determined and expect to last for the duration of his or her life. By signing this statement I certify that the information provided in the Physician's Statement is true and correct and that I am currently a licensed physician in _____(State).

My professional opinion is based upon a physical examination of _____
Name of Applicant
which I conducted on the _____day of _____, 20___.

_____ _____
Physician's Signature **Date**